Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble
Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: Montana
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

(Signature of Agency Head)
Maggie Bullock, Health Policy and Services Division Administrator
Department of Public Health and Human Services

SCHIP Program Name(s): Montana Children's Health Insurance Plan (CHIP)

SCHIP Program Type:
____Medicaid SCHIP Expansion Only
_X_Separate SCHIP Program Only
_____Combination of the above

Reporting Period: Federal Fiscal Year 2001 (10/1/2000-9/30/2001)

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(Due to your CMS Regional Contact and Central Office Project Officer by January 1, 2002)
Please cc Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program changes and progress during Federal fiscal year 2001 (September 30, 2000 to October 1, 2001).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 2000 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 2000, please enter "NC" for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

A. Program eligibility - The 2001 federal poverty guidelines were implemented April 1, 2001.

B. Enrollment process - NC

C. Presumptive eligibility – Not Applicable

D. Continuous eligibility – NC

E. Outreach/marketing campaigns - a statewide "Back to School" campaign coordinated with the Hot Lunch Program was conducted in August 2001. This campaign reached the families of 157,000 Montana children.

F. Eligibility determination process – All county Offices of Public Assistance are now processing and determining eligibility for CHIP coverage. The vast majority of CHIP applications continue to be processed by the Eligibility Staff at the state office.

In January 2001 the CHIP maximum enrollment of 9,700 children was met and a waiting list was instituted for children determined eligible for CHIP. Children who were on the waiting list were enrolled when current enrollees were either disenrolled or failed to re-enroll. The average time on the waiting list was 3 months.

See Section K. (below) regarding the co-location of CHIP and MHSP and the coordinated eligibility determination process.

G. Eligibility redetermination process – Re-Enrollment letters and applications are sent to families 60 prior to the expiration of CHIP coverage. Magnets with our toll-free number are included with the re-enrollment packet. A "reminder flyer" is sent 30 days prior to expiration. A survey of families who did not re-enroll their child's CHIP coverage was conducted. The report entitled "Why Some Parents Didn't Renew CHIP: Findings from the CHIP Retention Survey" is attached to this report.

H. Benefit structure – NC

I. Cost-sharing policies - NC

J. Crowd-out policies - NC

Delivery system – The delivery system remains unchanged but the number of providers has increased in FFY 2001. The network of BlueCHIP providers experienced a 29% increase and the network of CHIP dentists increased by 25%.

K. Coordination with other programs (especially private insurance and Medicaid) – Effective FFY 2001, all applications for children applying for the state's Mental Health Services Plan (MHSP) must first be screened for CHIP eligibility. The MHSP eligibility determination staff are now a part of our Health Care Resources Bureau and co-located with the CHIP staff. Eligibility staff have been cross-trained and process both MHSP and CHIP applications. This has resulted in streamlined eligibility determination, enrollment, coordination and referral between the programs.

L. Screen and enroll process – See response to Question K (above).

M. Application - The universal application was reviewed and minor changes were made for simplification and clarity.

N. Other – NC

1.2 Please report how much progress has been made during FFY 2001 in reducing the number of uncovered low-income children.

A. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2001. Describe the data source and method used to derive this information.

The number of enrolled children in the CHIP program at the end of this fiscal year is 9,700. This is 2,162 more children than the 7,538 children enrolled at the end of last fiscal year.

B. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

According to the Medicaid data system, there were 51,819 children eligible for Medicaid in FFY 2000 and 54,835 in FFY 2001. This represents a 6% increase. (The FFY 2001 number is not final and may increase due to possible retroactive eligibility.)

C. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

The Caring Program for Children, a public- private partnership administered by Blue Cross Blue Shield of Montana, provided coverage for 668 children at the end of FFY 2001 and there were 120 on the waiting list. There were 641 children covered at the end of FFY 2000.

The Children's Special Health Services, funded by Title V Maternal and Child Health block grant, provided reimbursement for services not covered by Medicaid, CHIP or other health insurance for 142 children during FFY 2001. They served over 1,000 children through special health clinics and public education.

CHIP worked closely with Blue Cross Blue Shield of Montana on the development and implementation of "Blue Care". This is a low-cost, limited health insurance plan for uninsured individuals and families.

D. Has your State changed its baseline of uncovered, low-income children from the number reported in your FFY 2000 Evaluation?

__X__ No, skip to 1.3

____ Yes, what is the new baseline?

What are the data source(s) and methodology used to make this estimate?

What was the justification for adopting a different methodology?

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

1.3 Complete Table 1.3 to show what progress has been made during FFY 2001 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as

specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State's strategic objectives for your SCHIP program, as specified in your State Plan.
Column 2: List the performance goals for each strategic objective.
Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter "NC" (for no change) in column 3*.

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
Objectives related to Reducing the Number of Uninsured Children		
Decrease the proportion of children in Montana who are uninsured and reduce financial barriers to affordable health care coverage	Decrease the proportion of children ≤ 150% FPL who are uninsured	Data Sources: Current Population Survey Methodology: 1994,1995,1996 merged data set (baseline) comparison with FFY 2001 data. Numerator: Number of children ≤ 150% FPL who were insured Denominator: Number of children ≤ 150% FPL Progress Summary: In FFY 2001 the number of uninsured children was reduced by 5,205 due to increased coverage by CHIP, Medicaid and The Caring Program for Children.
Objectives Related to SCHIP Enrollment		
Enroll eligible children in CHIP	Enroll 9,725 uninsured children who are ≤ 150% FPL during FFY 2001	Data Sources: Internal CHIP data system. Methodology: The number of enrolled children reported by the system through the end of FFY 2001

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		Progress Summary: At the end of FFY 2001, 9,700 children were enrolled in CHIP. Because of limited state funding, we were unable to draw down all federal funds. In FFY 2002 our enrollment cap was reduced to 9,300. There is a waiting list for newly eligible children.
Objectives Related to Increasing Medicaid Enrollment		
Increase the enrollment of currently eligible, but not participating children in the Medicaid program.	Ensure that 50% of children referred by CHIP to Medicaid become enrolled in Medicaid	Data Sources: NC Methodology: NC Progress Summary: Although CHIP has defined the information to be obtained in report format from the eligibility and enrollment data system, that data is not yet available. We expect it to be available in FFY 2002.
Objectives Related to Use of Preventive Care (Immunizations, Well Child Care)		
Improve the health status of children covered by CHIP with a focus on preventive and early primary treatment		Data Sources: HEDIS data gathered by Blue CHIP Methodology: DPHHS to review HEDIS date for CHIP enrollees Numerator: Number of CHIP enrollees with immunizations and well-child care Denominator: Number of CHIP enrollees Progress Summary: See Section 2.8
Other Objectives		
Coordinate and consolidate with other health care programs providing services to children to create a seamless health care delivery system of low-income children	Coordinate with Children's Special Health Services (CSHS) and the Mental Health Service Plan (MHSP) to ensure that children who need care beyond what is offered by CHIP are referred to these programs	Data Sources: Internal CHIP data system Methodology: Review and analysis of referral data to CSHS and MHSP Numerator: Number of children referred to CSHS and MHSP Denominator: Number of children needing care from CSHS and MHSP Progress Summary: There were 195 referrals from CHIP to CSHS in FFY 2001. During FFY 2001 all children who applied for MHSP

Table 1.3 (1) Strategic Objectives (as specified in Title XXI State Plan and listed in Your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
		were required to first apply for CHIP. As a result, most of those children were dually enrolled in CHIP and MHSP. There were some children who were not eligible for CHIP and were enrolled in MHSP only.
Prevent "crowd out" of employer coverage	Maintain proportion of children ≤150% FPL who are covered under employer-based plans, taking into account decreases due to increasing health care costs or a downturn in the economy	Data Sources: Current Population Survey Methodology: 1994,1995,1996 merged data set (baseline) comparison with FFY 2001 data. Numerator: Number of children ≤150% FPL who were insured through employer-based coverage Denominator: Number of children ≤150% FPL Progress Summary: We do not have access to information to adequately quantify this question. There is no source that we can find for the number of children at or below the poverty level who have employer insurance. We can locate the number of uninsured children through the census data from 10 years ago, however this does not begin to answer this question. See section 1.4 for suggestions on how we hope to address this objective.

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

From Section 1.3 – Objective 3: CHIP needs a stronger partnership with the counties to make sure applications referred for Medicaid determination are either denied or made eligible in a timely manner. CHIP needs to track those referrals more closely, and we will explore requiring an in-house Medicaid Eligibility Specialist who could focus solely on these referrals from CHIP.

From Section 1.3 – Objective 5: We are unable to track if the percentage of children referred by CHIP to CSHS for specific services, received the services for which they were referred. CHIP and CSHS will be in the same bureau and co-located in FFY 02 and will work together using an ad-hoc query tool to better determine this information.

From Section 1.3 – Objective 6: We have spoken with the numerous staff in the Insurance Commission and with the Census Bureau. The information requested regarding insurance coverage is limited at best. The Senior Policy Advisor for the Insurance Commissioner stated that with Montana's high-uninsured ratio of 18.5%, the crowd out of employer coverage is not an issue. The national average of uninsured is 14% with neighboring states being on the average of 11.5%. The reason for the high-uninsured rate in Montana is primarily because the employment base is made up of mostly small businesses. Even the majority of our larger businesses do not offer incentives towards dependent coverage. Most businesses barely cover the employee portion of coverage.

1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

Not Applicable

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

An Information Manager was hired in July 2001. Because of the waiting list for enrollees, volume of applications received, and backlog for application entry, the first responsibility of the IM has been to increase the efficiency of our eligibility data entry and accuracy. Many needed changes have been made to increase the efficiency of information processing. The next issue will be to focus on enhancing our program evaluation program in the following areas: outcomes, special populations, and quality of service in addition to HEDIS measures already being gathered.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here.

Retention Survey
2001 CHIP Enrollee Survey Results and Analysis

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage:

A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

Not Applicable

B. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2001 (10/1/00 - 9/30/01)?

___0__Number of adults
___0__Number of children

C. How do you monitor cost-effectiveness of family coverage?

Not Applicable

2.2 Employer-sponsored insurance buy-in:

A. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

Not Applicable

B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?

__0___Number of adults
__0___Number of children

2.3 Crowd-out:

A. How do you define crowd-out in your SCHIP program?

Crowd out is defined as the substitution of publicly funded health coverage for private health insurance.

B. How do you monitor and measure whether crowd-out is occurring?

The universal application asks if children currently have health insurance or if they've had health insurance in the past three months. Children must be uninsured

for three months before being enrolled in CHIP. (Some employment-related exceptions apply.)

C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

D. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

Anecdotal reports from applicants, outreach contractors, and the general public continue to indicate that the three month waiting period discourages potentially eligible families from substituting private insurance with public coverage. Most of those reports indicate that the three month waiting period is a hardship for families who are having difficulty affording private insurance but are fearful of the risk of being without any health insurance for their children for three months.

2.4 Outreach:

A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

The five outreach strategies employed were:

1) direct appeal to eligible families through press releases, public service announcements and videos;
2) outreach through schools;
3) outreach through collaboration with local community agencies, grassroot organizations and providers;
4) outreach collaboration with statewide maternal child health organizations, county health departments and county governments and
5) a statewide "Back to School" campaign with the Hot Lunch Program. This campaign reached the families of 157,000 Montana children.

Medicaid/CHIP outreach contractors and Montana Covering Kids advocates working in their local communities were highly effective. The advocates and contractors indicated that they found the following activities to be most successful:

- Working one on one with families to complete applications
- Sending information home to families with children attending Head Start programs, pre-schools, schools, WIC offices and county health departments
- Providing information and applications to doctors' and dentists' offices to distribute to parents whose children were insured.

We have not conducted studies to determine the effectiveness of individual outreach strategies and activities. We seek feedback from outreach contractors, advocates and families.

Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

The outreach activities listed above were successful for all populations. Door-to-door outreach efforts of Indian reservation were especially effective in reaching Native American families. Having a Native American person from the reservation provide the information and assistance in completing the application resulted in greater acceptance of the health coverage programs. On some reservations an outreach worker would assist families to complete their applications, screen the applications for completeness and submit the applications. The worker would also conduct follow-up with families to ensure that the children were enrolled in the health coverage programs that they needed. Outreach efforts by the staff at Indian Health Services or Tribal Health facilities were also extremely effective

Some of the more innovative settings and or approaches this year include the following:

- Richland County made up " Lunch Bags" (little white bags filled with promotional items) displaying phone numbers for the local advocates as well as the toll-free number for Kids Now. These were handed out at the Fairview "Old Timers Festival" this year. They found this to be an even better strategy than the previous year when they made a float for the Festival and threw Frisbees off into the crowd with the pertinent phone numbers attached to the inside of them. They reported that the one on one contact was a more successful strategy.
- One county advocate put the booklet, " When To Call the Doctor" into a bag with other fun promotional hand outs and delivered them to every doctor and dentist in the area. The advocate made an individual connection with the doctors or their receptionists and asked that the packets be handed out to their patients. Advocates also asked the offices to remind CHIP patients to make sure they re-enroll when it comes due.

- The Ravalli County outreach contractor organized people from the Forest Service, Ravalli County Kids First, Tobacco Free Ravalli County, WIC, Head Start, Darby Active and Resourceful Teens, Child Care Resources, Project Recovery, Literacy of America Bitterroot, the Office of Public Assistance and the Ravalli County Health Department to have the second annual Lake Como Healthy Families "Fun in the Sun Day. The event featured free toys, food and exciting activities for children of all ages. About 300 people from the area attended the event. This was a successful way to link families with health care programs as well as other community programs.

B. Which methods best reached which populations? How have you measured effectiveness?

See responses to Questions A and B above.

2.5 Retention:

A. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

To ensure that eligible children stay enrolled in CHIP we have implemented the following:

- 12 month continuous eligibility
- re-enrollment packet mailed 60 days prior to expiration of coverage
- follow-up letter to families who have not submitted their re-enrollment application mailed 30 days prior to expiration of coverage
- phone calls to families to obtain missing information necessary to determine eligibility

B. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

__X__ Follow-up by caseworkers/outreach workers
__X__ Renewal reminder notices to all families
_____ Targeted mailing to selected populations, specify population
_____ Information campaigns
__X__ Simplification of re-enrollment process, please describe

The CHIP Information Manager is in the process of designing a computer-generated re-enrollment form that indicates the information the applicant submitted on the previous application. The applicant will need only to report changes to this information and submit current documentation in order to re-apply. We believe this will increase the rate of re-enrollment of eligible children.

__X__ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe:

a retention survey by phone of families who did not re-enroll in CHIP (see In FFY 2001 we conducted attached copy of report).

____ Other, please explain

C. Are the same measures being used in Medicaid as well? If not, please describe the differences.

No. Medicaid is not undertaking any special measures. During FFY 2001 Montana Medicaid experienced an increase in both enrollment and expenditures and is facing a deficit. Cost-cutting measures are being considered and will most likely be implemented in FFY 2002.

D. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

Personal contact with applicants is the most effective but also the most cost-prohibitive. Due to limited state funding we instituted a waiting list in January 2001. The letter we send with our re-enrollment packet stresses that the application must be returned prior to the expiration of coverage to avoid a lapse in coverage. If the application is not received by that time, the eligible children will be uninsured and their names will be put on the waiting list. The average time on the waiting list varies but is between 2 and 4 months. Many families are motivated to submit their application early in order to avoid this situation.

E. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

Of the children who were disenrolled from CHIP by CHIP staff during their 12-month eligibility period, (48%) were disenrolled because they became eligible for Medicaid, 15% because they had other health insurance coverage. The source for this data is TESS, the eligibility and enrollment system.

Of the children whose CHIP coverage did not continue at the time of renewal, 38% had other health insurance. However, the survey was conducted one to six months after the expiration of coverage and the question addressed coverage at the time of the survey not at the time of expiration of CHIP coverage. (Future surveys will ask if the child had other insurance coverage the month after the expiration of CHIP coverage. The source for this data is the CHIP Retention Survey, 2001, attached.

2.6 Coordination between SCHIP and Medicaid:

A. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

CHIP uses a universal application for CHIP, Medicaid, MHSP, CSHS and The Caring Program. However, the application and redetermination requirements differ. CHIP has 12 month continuous eligibility and does not have an asset test. Medicaid has month to month eligibility, presumptive eligibility, a $3,000 asset test and requires a greater amount of supporting documentation than CHIP.

B. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

If at the time of CHIP re-determination, a CHIP child is found to be potentially eligible for Medicaid the application is forwarded to the applicant's county Office of Public Assistance for Medicaid eligibility determination and enrollment.

When children lose Medicaid coverage, county OPA eligibility staff can determine CHIP eligibility. CHIP- eligible children who have a sibling with CHIP are enrolled in CHIP; those who do not have a sibling with CHIP go on the waiting list until a space becomes available.

C. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

The delivery systems for CHIP and Medicaid are not the same, although the providers are often enrolled in both programs' networks. CHIP contracts with Blue Cross Blue Shield of Montana that has one of its responsibilities, enrolls and supports medical and allied providers as well as hospitals. The CHIP Program contracts with Affiliated Computer Services Inc. (ACS) to enroll and support dental and eyeglasses providers. Medicaid enrolls and supports its medical, allied and dental providers through two contractors, Maximus, Inc. and ACS, and directly through the state Medicaid program staff.

2.7 Cost Sharing:

A. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

Not applicable – there are no premiums or enrollment fees for Montana CHIP.

B. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

Anecdotal reports from families, outreach contractors and Montana Covering Kids advocates indicate that the co-pay amounts and co-pay maximum are reasonable and do

not appear to be a barrier to utilization of services. During the CHIP Retention Survey families were asked their reasons for not re-applying for CHIP and cost-sharing was not mentioned by any respondents. Therefore, we conclude that cost-sharing was not perceived by families as a barrier to re-enrollment either.

2.8 Assessment and Monitoring of Quality of Care:

A. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

- Quarterly complaint logs are kept by BCBS and forwarded to the Department. For FFY 01 there were 2 complaints. Both complaints were resolved with customer education**.** In addition, CHIP maintains a complaint log. In FFY 2001there were 8 complaints, 5 of which pertained to quality of care and were dealt with by CHIP staff.
- Network Adequacy: Each quarter we look at the total number of physician and hospital SCHIP providers in the state. If there is a significant change we look to assure that the change did not leave any region of the state with an inadequate network of providers.
- HEDIS measures are collected by BCBS annually and reported to us. The results were as follow:
    - Children's Access to Primary Care Providers:
        - 12-24 months old 93.33%
        - 25 mos-6 yrs. 80.94%
        - 7-11 yrs. 89.63%
    - Well-Child Visits:
        - 1st 15 months of life # of members was too small to use as a valid measure
        - Age 3-6 30.91% rec'd 1 or more visits
        - Age 12-18 31.15% rec'd 1 or more visits
    - Childhood Immunization status (2 yr.)
        - DTP (4) 31.25%
        - OPV/IPV (3) 37.5%
        - MMR (1) 56.25%
    - Hib (2) 37.5%
        - Hepatitis B (3) 18.75%
        - VZV (1) 25%
        - Combo 1 (all above except VZV) 18.75%
        - Combo 2 (all above) 0%
    - Adolescent Immunization status (13 yr.)
        - MMR (2nd) 62.26%
        - Hepatitis B (3) 16.98%
        - VZV (1) 1.89%
        - Combo 1 (all but VZV) 16.98%
        - Combo 2 (all above) 1.89%
- Survey

- Client survey sent out once a year (see copy attached). The 2001 CHIP Enrollee Survey Results and Analysis found the following:
- 93% of respondents rated their satisfaction with CHIP Program between seven and ten, with ten being "completely satisfied".
- 81% of respondents rated their understanding of the CHIP Program between seven and ten, with ten being "completely understand".
- 89% of respondents rated their child's personal provider between seven and ten, with ten being "best personal provider possible"; 47% rated their provider as a ten, "best possible personal provider".
- 78% of respondents rated their child's dental care between seven and ten, with ten being "best dental care possible"; 3% rated their child's care as a ten, "being "best dental care possible".

B. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

We use HEDIS measures, complaint and grievance data, and client survey (see above).

C. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

We will continue to use the methods discussed above.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2001 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

A. Eligibility

Success: Improvements have been made in both data entry and reporting capabilities of the eligibility data system.

B. Outreach

Success: There has been good coordination between statewide community-based organizations and DPHHS to educate and enroll eligible children in CHIP and other health coverage programs.

The Department also initiated thirteen outreach contracts statewide with Native America tribes, county health departments, county governments, and other non-profit community agencies to perform Medicaid outreach activities. (Federal Medicaid matching funds were accessed for these contracts.)

In addition to ongoing outreach efforts by the state outreach coordinator, MCK coalitions and Department contractors, a statewide "Back to School" campaign was conducted through the School Hot Lunch Program, reaching 157,000 Montana children.

C. Enrollment

Barrier: Because of an increase in the per member per month insurance premium, as well as limited state funding, we were unable to draw down all federal funds and we were unable to enroll all eligible children in CHIP. In January 2001 an enrollment cap of 9,700 children and a waiting list for eligible children was instituted.

In FFY 2001 the number of children enrolled was artificially high because we were able to use state funds from the previous fiscal year. As a result, in FFY 2002 the enrollment cap was reduced to 9,300 in December 2001

Success: CHIP continues to be a highly valued program in Montana. We have maintained a high application rate, and there is a high level of satisfaction with the program by enrollees.

D. Retention/disenrollment

Barrier: Some families failed to reapply for CHIP for their children even though they may have been eligible.

Success: A Retention Survey (see copy attached) was conducted with CHIP families who did not renew their children's CHIP coverage. Findings and recommendations of the survey will result in improvements to our renewal process in FFY 2002.

E. Benefit structure - NA

F. Cost-sharing - NA

G. Delivery system

Barrier: None of the anesthesiologists in Missoula, one of our largest cities, would participate in the BlueCHIP network of providers because of contractual issues. This resulted in an access to surgical care issue for CHIP children in the Missoula area. Fortunately, this issue was successfully resolved during this fiscal year and the anesthesiologists are providing care to CHIP children.

Success: Our insurance partner, BCBSMT, has created an extensive provider network. A BCBSMT official reported that it is a better network than for any other plan they offer -

due to the popularity of CHIP with providers. During this fiscal year, the network of BlueCHIP providers experienced a 29% increase from 2,379 (physicians=1,107; allied providers=1,174; facilities=98) to 3,061 (physicians=1,402; allied providers=1,520; facilities=139).

At the beginning of FFY 2001 there were 158 dental providers in 165 communities throughout Montana. By the end of FFY 2001 we had a network of 198 dental providers practicing in 206 locations. This represents a 25% increase in our number of CHIP dentists.

H. Coordination with other programs

Barrier: The process for coordinating with county Offices of Public Administration (OPA) for referrals for Medicaid eligibility determination has been cumbersome and inefficient. County OPA staff have been trained to do CHIP eligibility determination but there have been problems with referrals and enrollment.

Success: The Mental Health Services Plan (MHSP) eligibility staff was integrated into our section. CHIP and MHSP staff are cross-trained to process applications for both programs. Referral and follow-up of applications for children who need both programs has improved.

CHIP and Children's Special Health Services (CSHS) staff worked with the CompCare technical assistance (TA) initiative to improve the services available to children with special health care needs (CSHCN) in our state. This TA initiative is funded by HRSA/MCH Bureau and is sponsored in collaboration with CMS. The goal of the TA initiative is to learn more about the services families need and use for their CSHCN, including who pays for the services and what services are needed but are unavailable or inaccessible. Work on this initiative will continue in FFY 2002.

I. Crowd-out - NA

J. Other

Barrier: The Customer Service Survey indicated that many CHIP enrollees did not receive preventive care. Additionally, many enrollees expressed concerns about access to dental care.

Success: The Customer Service Survey indicated as high level of satisfaction with CHIP by enrollees and families. It also showed that the enrollees tend to use the materials provided by CHIP and rate the usefulness of the materials as high.

SECTION 4: PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 **Please complete Table 4.1 to provide your budget for FFY 2001, your current fiscal year budget, and FFY 2002-projected budget. Please describe in narrative any details of your planned use of funds.**

N*ote: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00).*

	Federal Fiscal Year 2001 costs	Federal Fiscal Year 2002	Federal Fiscal Year 2003
Benefit Costs			
Insurance payments			
Managed care			
__per member/per month rate X __ of eligibles	12,901,745	12,073,842	12,072,755
Fee for Service	3,184,225	2,641,188	2,515,201
Total Benefit Costs	16,085,970	14,715,030	14,587,956
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs	16,085,970	14,715,030	14,587,956
Administration Costs			
Personnel			
General administration			
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/marketing costs			
Other			
Total Administration Costs	992,615	1,471,503	1,458,795
10% Administrative Cost Ceiling	1,608597	1,471,503	1,458,795
Federal Share (multiplied by enhanced FMAP rate)	13,855,722	13,072,244	12,959,357
State Share	3,309,613	3,114,289	3,087,394
TOTAL PROGRAM COSTS	17,078,585	16,186,533	16,046,751

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2001.

Not applicable - Montana CHIP does not have family coverage.

4.3 What were the non-Federal sources of funds spent on your SCHIP program during FFY 2001?

__X__State appropriations
_____County/local funds
_____Employer contributions
_____Foundation grants
_____Private donations (such as United Way, sponsorship)
_____Other (specify)

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures?

No change in the sources of the non-Federal share of the plan expenditures is expected.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	**Medicaid Expansion SCHIP program**	**Separate SCHIP program**
Program Name		Montana SCHIP
Provides presumptive eligibility for children	_____No _____Yes, for whom and how long?	__X__No _____Yes, for whom and how long?
Provides retroactive eligibility	_____No _____Yes, for whom and how long?	__X__No _____Yes, for whom and how long?
Makes eligibility determination	_____State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)*	__X__State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff __X__Other *(specify)* SCHIP Eligibility Staff
Average length of stay on program	Specify months	Specify months _____12 months
Has joint application for Medicaid and SCHIP	_____No _____Yes	_____No __X__Yes
Has a mail-in application	_____No _____Yes	_____No __X__Yes
Can apply for program over phone	_____No _____Yes	__X__No _____Yes
Can apply for program over internet	_____No _____Yes	__X__No _____Yes
Requires face-to-face interview during initial application	_____No _____Yes	__X__No _____Yes
Requires child to be	_____No	_____No

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
uninsured for a minimum amount of time prior to enrollment	_____Yes, specify number of months What exemptions do you provide?	__X__Yes, specify number of months __3 months What exemptions do you provide? If a parent or guardian dies; was fired or laid off; can no longer work due to a disability; has a lapse in insurance coverage due to new employment; or has an employer who no longer offers dependent coverage.
Provides period of continuous coverage regardless of income changes	_____No _____ Yes, specify number of months Explain circumstances when a child would lose eligibility during the time period	_____No __X__Yes, specify number of months __12 months_____ Explain circumstances when a child would lose eligibility during the time period When a child obtains Medicaid or other creditable health insurance, turns 19, moves out of state or dies.
Imposes premiums or enrollment fees	_____No _____Yes, how much? Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify)	__X__No _____Yes, how much? Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify)
Imposes copayments or coinsurance	_____No _____Yes	_____No __X__Yes - Maximum out of pocket expense of $215 per family per benefit year.
Provides preprinted redetermination process	_____ No _____ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	__X__ No _____ Yes, we send out form to family with their information and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

The application must be completed and submitted with required documentation for both the initial application and the redetermination process. However, 60 days prior to the expiration of coverage current CHIP families are mailed an

application and notified that they need to reapply. At 30 days a reminder notice is sent to the family if a completed application has not yet been received by the CHIP office. Applications from families who are reapplying for SCHIP are given priority in processing in order to avoid a lapse in coverage.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2001, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher

__133__% of FPL for children under age __6_____
__100__% of FPL for children aged 6 or born after 10-1-83
_40.5__% of FPL for children aged born before 10-1-83

Medicaid SCHIP Expansion

____% of FPL for children aged _____
____% of FPL for children aged _____
____% of FPL for children aged _____

Separate SCHIP Program

_150__% of FPL for children aged 0-18_____
____% of FPL for children aged _____
____% of FPL for children aged_____

6.2 As of September 30, 2001, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA".*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination)

____ Yes __X__ No

If yes, please report rules for applicants (initial enrollment).

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	Separate SCHIP Program
Earnings	$120/mo./each earner	$	$120/mo./each earner
Self-employment expenses *	$	$	$
Alimony payments Received	$	$	$
Paid	$	$	$
Child support payments Received	$	$	$
Paid	$	$	$
Child care expenses	≤ $200/mo./child	$	≤ $200/mo./child
Medical care expenses	$	$	$
Gifts	$	$	$
Other types of disregards/deductions (specify)	$	$	$

* Depreciation of business equipment; self-employment taxes – amount varies.

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups

___No _X_Yes, specify countable or allowable level of asset test_$3,000___

Medicaid SCHIP Expansion program

__ No____Yes, specify countable or allowable level of asset test_____

Separate SCHIP program

_X_No____Yes, specify countable or allowable level of asset test_____

Other SCHIP program_____

____No____Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2001?

___ Yes __X_ No

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2002(10/1/01 through 9/30/02)? Please comment on why the changes are planned.

A. Family coverage - NC

B. Employer sponsored insurance buy-in - NC

C. 1115 waiver - NC

D. Eligibility including presumptive and continuous eligibility - NC

E. Outreach – The Department's thirteen outreach contracts with the Native American tribes, county health departments, county governments and other non-profit agencies for outreach and application assistance expire on December 31, 2001. Due to a lack of funds and a waiting list for enrollment in CHIP there are no plans to renew these contracts.

The maximum number of CHIP enrollees was met in January 2001 and a waiting list was established. Children on the waiting list become enrolled when current enrollees are either disenrolled (turn 19, die, move out of state, obtain Medicaid or other health coverage) or fail to reenroll in CHIP. Our outreach strategies for FFY 2002 are to educate our current enrollees about the importance of the following:

- using their insurance for preventive care services and
- submitting their reenrollment prior to expiration of CHIP coverage

We plan to develop a quarterly newsletter for all enrollees and families on the waiting list with the above information and other updates.

F. Enrollment/redetermination process - We conducted a Retention Survey in FFY 2001 to determine why some parents did not renew CHIP for their children before coverage was terminated (at the 1 year anniversary). As a result of the findings, we are making the following changes in our renewal process in an effort to increase the retention of current CHIP enrollees:

- We are sending a postcard to current enrollees 2 weeks prior to the mailing of their renewal packet to advise them that the packet is coming and the importance of returning the application promptly.

- We will develop an income and expense form for families who are self-employed. This form may be submitted instead of a tax return. (Some

families indicated that they missed the renewal deadline because they were waiting for their tax returns to be completed.)

- We are developing an abbreviated application form for CHIP families to complete for renewal. This form will indicate the information submitted on their previous application. The applicant will update the information, attach current income documentation and return to the CHIP office. We believe this abbreviated application will result in more families renewing CHIP in a timely manner and avoiding lapses in their children's coverage.

G. Contracting – No contracts for outreach services (see response to Section E. above)

H. Other – The Children's Special Health Services (CSHS) section will be integrated into our Health Care Resources Bureau and we will be co-located. We expect this to result in a greater coordination of our services, a more efficient referral process and improved health coverage and care for children.

We plan to conduct additional training with county OPA staff to improve both the enrollment and referral process for CHIP and Medicaid.

We plan to educate CHIP families about the importance of dental care and provide them with a list of CHIP dentists and their policies for accepting new patients. Access to dental care is a statewide problem for Montanans regardless of income level or insurance coverage.

We plan to focus on enhancing our program evaluation in the following areas: outcomes, special populations, and quality of service, in addition to HEDIS measures already being gathered.

We will continue to work with CSHS on the CompCare TA initiative for children with special health care needs.